

CARTERET COUNTY

PUBLIC SCHOOL SYSTEM

A Beacon for Learning and Leading

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www.carteretcountyschools.org

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Voluntary Shared Leave Application

Please return completed form to the personnel office, Att: FMLA Representative

Employee's Full Name:

Patient's Name and Relationship to Applicant:

Last 4 digits of SSN#: Phone:

Work Location:

Home Address:

Description of Medical Condition:

Would you like your Voluntary Shared Leave participation sent to all schools and departments? Yes No

Note: Either a Doctor's Certification on the backside of this form must be completed or a doctor's statement containing the necessary information must be attached before the application will be considered.

I, request participation in the Voluntary Shared Leave Program due to the above-mentioned medical condition. I hereby authorize the release of the above-mentioned information for the purpose of receiving leave as prescribed by the Voluntary Shared Leave Program policy. I further authorize my treating physician to release any information acquired in the course of my examination(s) or treatment(s) to my employer as indicated for purposes of receiving donated leave in accordance with the Voluntary Shared Leave Program Policy.

I understand that I may not force or coerce any individual into donating leave. The donation of leave under this program shall be entirely voluntary. If the use of force or coercion is discovered, it will be viewed as unacceptable personal conduct and dealt with accordingly. I also understand that under no circumstances may the use of voluntary shared leave exceed my period of treatment or recovery.

Applicant's Signature: Date:

Approved by: Date:

MISSION

We will inspire, educate, and empower students for life through relationships, knowledge, and opportunity.